Permission Form for Prescribed
Medication/Treatment

***ALL MEDICATION/TREATMENT MUST BE ADMINISTERED BY SCHOOL PERSONNEL IN THE MAIN OFFICE.**

Date received by school _____ DOB: _____
Student Name: _____(Please Print) Grade: _____
Reason for medication _____
Name of medication_____

Form of medication (CIRCLE): tablet/capsule liquid inhaler injection Nebulizer other

Instructions:
_____
_____

Start: _____ (Date form is received) Stop: _____ (End of school year)

Restrictions/or important side effects: none anticipated

If yes, please describe:

_____

Special storage: none refrigerate other _____

Please indicate if you have attached additional paper with this form to provide additional information regarding your child's medication.

_____

Date: _____. Signature: _____
Physician's Name _____
Address _____
Phone Number _____

To be completed by parent/guardian:
I give permission for (name of child) _____ to receive the above medication/treatment at school according to standard school policy.

Date: _____ Guardian Signature: _____